

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040555

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9717

STATE FILE NUMBER

FILED OCT 19 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis

Length of stay in 1b
50 Y rs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Bethesda Hospital

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
3211 Utah

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First
NORA

Middle
A.

Last
MUELLER

4. DATE OF DEATH

Month Day Year
Oct. 8, 1962

5. SEX

Female

6. COLOR OR RACE

White

7. Married

Widowed ☒ Never Married ☐ Divorced ☐

8. DATE OF BIRTH

2/8/91

9. AGE (last birthday)

71

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (City and state or country)

Batchtown, Ill.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

John Delonay

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Address

Henry Mueller, 3211 Utah, St. Louis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Conditions, if any, which give rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

420.1F

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

fracture of left femur on 9-18-62

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

☒ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

fell in basement of home

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home 16

20f. CITY, TOWN, OR LOCATION

St. Louis

COUNTY

Mo.

21. I attended the deceased from 11-8-57 to 10-8-62 and last saw him alive on 10-8-62

Death occurred at 12:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Design or title)

A. T. Mueller MD

22b. ADDRESS

3507 Delmon

22c. DATE SIGNED

10/9/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

10-12-62

23c. NAME OF CEMETERY OR CREMATORY

Sunset

23d. LOCATION (City, town, or county)

St. Louis Co., Mo.

24. FUNERAL DIRECTOR

ADDRESS

McLaughlin, 2301 Lafayette,

25. DATE RECD. BY LOCAL REG.

OCT 10 1962

26. REGISTRAR'S SIGNATURE

W. and A. M. D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.